

Journal of Rural and Community Development

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Citation:

Yonge, O., Myrick, F., Ferguson, L., & Grundy, Q. (2013). Multiple lenses: Rural landscape through the eyes of nurse preceptors and students. *Journal of Rural and Community Development*, 8(1), 143-159.

Publisher:

Rural Development Institute, Brandon University.



Editor:

Dr. Doug Ramsey



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Multiple Lenses: Rural Landscape through the Eyes of Nurse Preceptors and Students

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Abstract

In a recent photovoice study, fourth year nursing students and their rural nurse preceptors provided us with photographs and commentary documenting their everyday, lived realities, from which we constructed a narrative of preceptorship in the rural nursing context. We found that rural nursing integrates professional and community values, and that landscape mediates this integration in four ways: travel, occupationalism, historicity, and symbolic projection. Rural preceptorships introduce nursing students to dichotomous perceptions of landscape, derived from rural nurses' multiple roles and the competing scripts of official policy versus community bonds. Disseminated in media-rich formats such as exhibitions, photo-essays and online resources, these findings amount to a compelling message to prospective rural nurses, educators, and policymakers: rural nursing is a specialty, too long marginalized, with its own unique challenges and rewards.

Keywords: landscape, rural, nursing, preceptorship, Gemeinschaft, photovoice

1.0 Introduction

“We are the children of our landscape,” writes Lawrence Durrell in *Justine* (1957/1991, p. 41); “It dictates behavior and even thought in the measure to which

we are responsive to it.” In the context of rural nursing, Durrell’s words have particular resonance. Landscape is a significant determinant of rural nursing practice, insofar as it shapes (and is shaped by) the socioeconomic circumstances of a rural community, and gives rise to challenges and rewards that define rural health care (Weinert & Burman, 1999, p. 77-78). These premises were borne of the photographs and voices of nursing students and their rural preceptors, whom we recruited to document the everyday realities of teaching and learning about rural nursing through a photovoice research project. Our findings illustrate that landscape may inform rural identity; however, in the case of rural nurses and their preceptees, identity may also inform perceptions of the rural landscape.

For our purpose, landscape signifies the physical features (natural and man-made) of a rural community and its environs. Landforms, waterways, marshes, wood- and grasslands, and their associated ecologies, along with buildings, infrastructure, natural resources, and their associated industries, are all elements of landscape. Time is an additional dimension to be considered in any discussion of rural landscape and health care, whether in the seasonality of economic sectors such as agriculture and tourism (Zawaduk, 2011) or in the historicity of landmarks that encode rural identity.

Over the course of eighteen months in 2009-2010, a cohort (n=8) of rural Canadian nurse preceptors and preceptees provided us with over 800 digital images, and accompanying commentary, documenting the reality of rural nursing as they experienced it. We employed this participatory research method, known as photovoice (Wang & Burris, 1997), in the service of two primary objectives: 1) to construct a narrative of rural nursing and rural preceptorship, and 2) to promote rural placements for fourth year baccalaureate nursing students. Photovoice is advantageous in eliciting tacit cultural knowledge pertaining to difficult concepts such as “rural” (Leipert & Anderson, 2012; Wendling et al., 2005). In turn, the media-rich data yielded by this method are conducive to compelling, message-centered end products such as exhibitions, photographic essays, and online media.

Our enquirer stance was influenced by legislators’ urban-centric propensity to marginalize the concerns voiced by rural nurses (Jackman et al., 2010), and underlain by noteworthy statistics. Between 2000 and 2004, the number of registered nurses (RNs) practicing in rural and remote locations dropped from 17.9% to 17.1% of the total number of Canadian RNs (Canadian Institute for Health Information, 2002, 2006), while the number of rural residents in Canada held steady at approximately one fifth of the total population.

Rural preceptorship placements for senior nursing students are a proven strategy for recruiting nurses to rural health care settings (Bushy & Leipert, 2005; Neill & Taylor, 2002; Van Hofwegen et al., 2005); however, educators and rural hospitals require the tools to advocate for such placements, particularly to students from non-rural backgrounds. To this end, Bushy and Leipert (2005) recommend the inclusion of rural theory and practice perspectives in nursing studies. Our study presents one such initiative.

A number of significant themes emerged from our data. Rural nurses 1) bring a strong sense of community ethos to their clinical practice; 2) strive to maintain a professional culture of teaching and learning in the face of significant obstacles; and 3) confront challenges in uniquely rural ways such as ‘making do’ and coping through mutual support. Underpinning each of these themes is a prevailing notion

of landscape that, as our data suggest, mediates every aspect of a rural nurse's lived reality. In this article, we explore four aspects of such mediation: travel, occupationalism, historicity, and symbolic projection.

2.0 Rurality and Nursing

Zawaduk (2011) makes extensive use of Tönnies' [1887(2002)] distinction between *Gemeinschaft* (community) and *Gesellschaft* (society) in her discussion of rural nursing practice and preceptorship, which in turn provides a useful basis for our own background. *Gemeinschaft* is exemplified by the personal kinship-like bonds between rural residents, necessary for mutual survival, such as trust, loyalty, neighbourliness, and fellowship. *Gesellschaft*, by contrast, signifies an impersonal corporate or bureaucratic social order, such as a hospital. The tension between *Gemeinschaft* cultural norms of the rural community and the *Gesellschaft* policy-driven culture of health care is a defining feature of rural nursing (Zawaduk, 2011, p. 159).

Long and Weinert (2010, pp. 9-10) have built a theory of rural nursing based on several key concepts: 1) rural residents equate health with productivity; 2) isolation and long distances define rural living; 3) rural residents prefer self-reliance and informal support networks to the health care system and its bureaucracy; 4) anonymity is difficult to maintain in rural communities; and 5) rural identity (and *Gemeinschaft*, by extension) is built on the dialectics of insider/outsider, old-timer/newcomer. For rural nurses, the implications include visibility in the community context, permeable work-life boundaries, role diffusion, and difficulties maintaining confidentiality (Long & Weinert, 2010; Mills et al., 2007).

The postmodern view of place, a notion constructed by those who inhabit it, has lately made its way into a number of rural health care studies. In a study of rural palliative care, Castleden et al. (2010) observe that "place" has a constructed social dimension with potentially negative implications for end-of-life care experiences. The *Gemeinschaft* "sense of connectedness" described by Wendling et al. (2005) has long been attributed to rural communities; however, a darker side of rural *Gemeinschaft* can be seen in the psychosocial trauma endured by those who do not fit the traditional values of a rural community (Watkins & Jacoby, 2007). Rural nurses may feel marginalized by urban-centric policymakers (Jackman et al., 2010), but the social construct of rurality can have unhealthy, marginalizing effects of its own.

Zawaduk (2011, p. 102) identifies several key aspects of landscape (density, time, ethnicity, economics, resources, public health) as having a bearing on rural nursing and rural preceptorship, and stresses "the inter-relatedness of these themes within and across domains". Whether as physical reality or social construct, sense of place is the common denominator in all discussions of rural health care. Our primary research goals, involving the construction of a narrative of rural nursing and rural preceptorship through photovoice, and promoting the recruitment of new nurses to rural settings, were partly inspired by the recognition that landscape is seldom far from the daily concerns of a rural nurse.

3.0 Method

3.1 Ethics

Prior to recruiting participants, approval was gained from the respective university research ethics boards. Permission for the research was obtained from the deans and

designates of the respective nursing faculties, and from each prospective data collection site. Given the particular challenges of maintaining participant privacy and anonymity in photographic research (Catalani & Minkler, 2010; Harrison, 2002), the team members consulted a medical photographer for ethical guidance regarding photography in health care settings. Pseudonyms are used throughout this article.

3.2 Recruitment and Orientation

In conventional photovoice methodology, researchers designate a “facilitator” or community expert to act as liaison, recruiter, trainer, discussion leader, and community advocate (Wang & Burris, 1997). This was not required for this study, even though the primary participants (n=8) were dispersed across six health care sites in two Canadian provinces. The researchers were familiar with the professional context of the study and knew how to negotiate through formal procedures and informal norms in the settings. Ethically, the researchers had to avoid the potential of power relationships and took care to recruit only participants with whom they had no prior academic or professional relationship.

Clinical instructors and the researchers recruited nursing students enrolled in their final clinical practica, who in turn requested their preceptors to participate in the study. The sample consisted of four 4th year undergraduate nursing students (one male and one female in Alberta, one male and one female in Saskatchewan) and four preceptors (all female), comprising two acute care RNs in Alberta, and one acute care RN and one home care RN in Saskatchewan. Two preceptors had less than five years’ practice experience, while the other two had greater than ten. The Alberta students underwent preceptorship rotations in single, rural acute care sites, while the Saskatchewan students split their practica between acute and community care settings. Both female students opted for placements in their home towns, while the male students traveled daily to communities less than 100 km (62 mi) distant.

The communities had populations ranging from 500 to 10,000, and all were located at least 80 km (49.7 mi) from a major regional hospital, as per Van Hofwegen et al.’s (2005) definition of “rural”. The historically crucial industries in the region were grain production and cattle ranching, which have more recently been supplanted by oil and gas extraction. This observation is pertinent to our study insofar as place can be viewed as an “occupationscape”, encoding the identity of its inhabitants (Hudson et al., 2011). While Canadian rural landscapes and perceptions of rurality are still predominantly agricultural, “the rural people-scape is decidedly nonagricultural” (Bollman & Reimer, 2009, p. 135), suggesting a growing disconnect between the agricultural identity of rural people and their lived reality as workers in other sectors.

The project coordinator discussed the purpose and ethical clearance of the photovoice study with each participant in turn, advising them they would be free to withdraw at any point. Each participant was given a 10-12 megapixel digital camera and a short orientation of its use. They signed a release to the rights of the data produced, and assumed responsibility for acquiring written photographic consent from all individuals taking or appearing in pictures.

During the orientation, participants were asked to act as “photojournalists for [their] rural setting, to show others outside of their setting what teaching and learning in rural health care is like”. The orientation sessions also addressed the power structures and ethics of photography (Wang & Burris, 1997); protocols for

acquiring consent from human photographic subjects; requirements for inclusion of photographs; ownership rights to the data; digital camera operation; and fundamentals of photography.

3.3 Data Collection, Analysis, and Rigor

Data collection took place in two stages: 1) four weeks of orientation, wherein participants photographed more overt aspects of their culture, and 2) a further four weeks to explore in depth themes, issues, and theories emerging from a midpoint discussion with members of the research team (Wang & Burris, 1997). The second stage concluded with an endpoint discussion. Midpoint and endpoint discussions averaged approximately ninety minutes each, and took place at the rural care sites where research was carried out. A group discussion format was employed, comprised of the students, their preceptors, and members of the research team, wherein commentary was invited with open-ended questions such as “what do we see here?” and “what does this photo mean to you?” (Hergenrather et al., 2009). These discussions were recorded and transcribed for subsequent analysis.

Together with our participants, we reviewed and discussed over 800 photographs, from which we selected about 100 images for publication. Criteria for selection included 1) the amount of discussion a photograph generated; 2) representativeness of a class of photographs (e.g. multiple photographs of highways, wheat fields, hospital beds); and 3) ethical suitability. The latter obliged the researchers to reject several powerful and meaningful images, such as those depicting frontline contraventions of health care policy, lest they compromise the participants.

Upon completing the collection phase, the participants’ photographs and comments were imported into NVivo 8 for coding and thematic analysis. Coding entailed the assignment of data to conceptual “nodes” or categories, based on native concepts emerging from the group discussions. As coding proceeded, some nodes (e.g. “teamwork”, “making do”, “coping and supporting”) gained in volume and significance, while others were absorbed or relegated to secondary status. Ultimately, the team arrived at a thematic tree comprising a small number of major conceptual nodes at its trunk, and a larger number of branches of secondary nodes.

To establish rigor the researchers organized selected images according to these thematic nodes, captioned with participants’ remarks, into a PowerPoint slideshow that was displayed for participants in onsite follow-up sessions. Participants not only corroborated and expanded on their earlier remarks, but also corroborated data from the other sites.

These follow-up sessions were also recorded and imported into NVivo 8, whereupon the researchers further refined the themes and ultimately constructed the rural nursing narrative, employing it to construct a book and online slideshow entitled *Through Their Own Eyes: Images of Rural Nursing*, available online at www.clinicalnursing@ualberta.ca. A copy of this book was given to each participant and the clinical site in recognition of their contributions. It was also given to the professional organizations, libraries, and to members of the Ministry.

4.0 Findings

The participants were asked to tell the story, through photography, of teaching and learning to nurse in rural settings. Approximately one quarter of their photographs were landscapes of rural towns and surrounding countryside: a strikingly high

proportion, which prompted the researchers to explore in the group discussions how landscape might mediate the experience of rural nursing and rural preceptorship. Travel, occupationalism, historicity, and symbolic projection were the most prominent themes articulated during these discussions.

4.1 Travel

The participants took dozens of highway pictures. A few of these were self-explanatory roadside tableaux of canola and wheat. Many more photos focused on the road itself, and these rather windshield images had significance for their authors. “When you’ve driven gravel roads to try and find someone’s farm, you soon appreciate the highways,” remarked Brandy (student), touching on a less conspicuous challenge of rural home care. For Bev, the home care preceptor, the car doubled as a report room: “I kind of gave [Brandy] a little bit of background information: what we were dealing with, how to approach certain people... we had a few [clients with whom] we had to really be careful, how we approached [them].”



Figure 1. “When you’ve driven gravel roads to try and find someone’s farm, you soon appreciate the highways.” (Brandy, student)

Highway time was a significant part of the weekly, and sometimes daily, routine for every participant. Road photographs generally evoked pleasant memories. “I wanted to capture... this idea that rural nursing was open highways when you’re driving to work, and this was by far one of my favorite things,” explained Kevin (student), chuckling at the perspective through his insect-spattered windshield. “I don’t have to go through traffic in [the city]... so it’s a nice, relaxing drive.” Serenity, personal space, and scenic vistas all made the highway an anodyne counterpoint to the periodic stresses of rural nursing. “We go to [a neighboring town] all the time for hockey,” said Meg, an acute care preceptor and dedicated hockey mom. “This picture doesn’t do [the view] justice... it’s amazing.”

From the clinical standpoint, highway travel had more serious implications: limited supplies and long distances could lead to compromised care situations. “This is a picture of one poor fellow who ended up needing a ton of blood,” Sharon (preceptor) recalled, grimacing. “His family had to run to the city to get it... An hour-and-a-half

drive, an hour of waiting, an-hour-and-a-half back, and [we gave] him blood that evening.” Motor vehicle accidents [MVAs] were also commonplace, as Jackie (preceptor) explained. “We are right off the highway—right off the four-lane—so we do get a lot of MVAs: people hitting deer and all that stuff from the highway, because it is so close.” John (student), struck by the regularity of such occurrences, considered them in hindsight to be an invaluable part of his preceptorship experience. “There [were] a couple of MVAs, and we were the code team. I would probably not have had that opportunity in an urban setting.”

4.2 Occupationalism

In at least one instance, participants spoke of MVAs as a consequence of heavy industry in the region:

Meg (preceptor): I was driving [here from a neighboring town] today and I counted—how many near-accidents did I have? — It was four.

Brandy (student): With oil trucks... they’re not good drivers.

Over the course of their preceptorships, students learned to view landscape through the lens of rural nursing. Knowing which industries were prevalent, along with the patterns, attitudes, and lingo of workers employed therein, was essential for care. Kevin (student) took a picture of a John Deere tractor dealership, explaining, “Farming is a big part of the community here. You see that with the patients; you see that in the way [the town] is set up.” Brandy (student) put it in simpler terms: “If you’re going to work in [this town], you better know what a swather is, so when you get a trauma alert that someone got hit by a swather, you know what to expect.”



Figure 2. “You just have to know the types of attitudes that go along with farming... a gentleman south of town came about an hour and a half in. A round bale had fallen on his head. He [insisted] he was fine and he had a broken C2 [vertebra].” (Meg, preceptor)

Photos of round hay bales, livestock, industrial machinery, pump jacks, wellheads, and pipelines were all highly significant for participants. In these socioeconomic, occupational aspects of landscape, they saw the hazards that accounted for so many

specific health care issues, and a barometer of overall community health. “I wanted to take a picture of pump jacks,” explained Sharon (preceptor), “because our livelihoods and our husbands depend on having jobs, and [the oil patch] is a big employer—and it may *not* be soon.” Carla, her student, provided a picture of cattle from her farm, saying, “Most [ranchers] are selling, because they don’t have the feed to put up.” Bev (preceptor) further illustrated how occupationalism could be a locus for the insider/outsider dialectic of rural identity, commenting on her photograph of a cattle drive: “Everything stops and nobody thinks anything of it. No horns are honking.”



Figure 3. “Our livelihoods and our husbands depend on having jobs, and [the oil patch] is a big employer—and it may not be soon.” (Sharon, preceptor)



Figure 4. “Everything stops and nobody thinks anything of it. No horns are honking.” (Bev, preceptor)

4.3 Historicity

Small towns and their environs can be living museums. Our participants proudly shared with us photographs of old train stations re-purposed as teahouses, gift shops, and inns; ancient grain silos and barns (a few tilting toward oblivion); murals and monuments dedicated to community history; and health care equipment still in working order after decades of use. “We don’t waste our resources,” said Bev (preceptor), displaying a picture of a crank-operated bed. Sharon (preceptor) photographed a vacuum suction pump at her hospital, remarking, “That could be in a museum.” Both nurses were at pains to emphasize that these vintage resources functioned just as effectively as their modern counterparts, proffering them as evidence of the thrift, resourcefulness, and ingenuity incumbent on rural living.



Figure 5. “A little bit of our past.” (Sharon, preceptor)

The historicity of the rural landscape, both in the health care setting and the community at large, supported our participants’ sense of community in two ways. In their clinical practice, they felt a shared tradition of “making do” with limited and aging resources, much as did their fellow rural residents and clients. “When all else fails, we either fix it or make it. If we don’t have it, we will invent it,” said Sharon (preceptor); “If some cast isn’t doing something right, or we have to splint somebody—it’s amazing, some of things we’ve built.” More generally, older buildings and monuments fostered a sense of continuity with the past, and evoked traces of founding ethnicities. First Nations tepees, a Scandinavian “troll park,” and a century-old Hungarian church, were all palpable imprints of identity on place and place on identity.



Figure 6. “I had the opportunity to help assemble a teepee. ...It’s amazing, the symbolism that goes into [it].” (John, student)

Remarkably enough, in three of the four documented acute care sites, old hospital buildings had given way to modern, urban-style health care centers. Our participants were generally nonplussed by these displays of governmental largesse. Sharon’s picture of the brand-new “trauma” sign in a recently opened ward was laden with irony: “Hopefully our services won’t be cut,” she sighed. Jackie (preceptor) echoed this sentiment: “Our medicine unit’s closed right now... we went from thirty-six beds down to twenty-three... we just couldn’t staff it.” Even over the stretch of a few weeks, the disconnect between new facilities and lack of staff (and clients) to occupy them was not lost on John (student), who took pictures of a spacious, deserted inpatient ward. “I think it’s a great place for patients to be,” he said, clearly frustrated. “So much of it is under-utilized.”

Meanwhile, Sharon (preceptor) drew our attention to a photograph of a quaint, pre-World War II building surrounded by antique farm equipment: “This is the old hospital,” she explained, “which is now our museum.”

4.4 Symbolic Projection

John’s (student) favorite photographic landscape also now exists somewhere (we presume) as a painting:

I was just touring part of the [First Nations] reserve and I came [upon] an artist, just over here [to the left]. And he’s painting this picture of the reserve, and there’s a little lake here.... And I said, ‘you know, I just really appreciate the beauty of this, and I admire what you’re doing,’ and he says, ‘yeah... welcome spirit.’ This is in the valley here; it’s just like [a] welcome spirit, and that describes the whole experience for me: I got a sense [that] this is calm, peaceful... a welcoming spirit. [First Nations] culture is... so in tune with their environment... that really comes through,

and I thought this was just appropriate, so I took some pictures from this hill that this artist was painting from.

John touches on a typical attitude amongst our participants toward landscape: open, unspoiled vistas symbolize the character of the community. This may help to explain why the preceptors and their students placed such a premium on highway time. It afforded them the opportunity to re-engage with an open, serene sense of self *qua* rural, away from the pressures of the health care setting.



Figure 7. “There was an artist just over [on the left hand side], painting this picture of the reserve... he said ‘Welcome Spirit’. ...it sums up [my] whole experience in two words.” (John, student)

Meg (preceptor) took an equally striking photograph, this one of a sunset prairiescape featuring a dramatic sky, and the silhouette of a distant pump jack on the horizon. “Land of the Living Skies,” she said archly, quoting the provincial tourism board. “The mosquitoes [were] biting the heck out of me. I’ve seen a lot of dead birds.” Juxtaposing a well-worn tagline with the prospect of a West Nile virus outbreak; that is, dead birds falling out of living skies, which speaks to a subtle disconnect in the complex relationship of rural nursing and landscape. As a rural resident, Meg could still perceive the constructedness of notions of place, and how health care realities can shatter such notions; nonetheless, her picture found its way onto the cover of our book.



Figure 8. “Land of the Living Skies.” (Meg, preceptor)

5.0 Discussion

Photography and group discussion enabled our participants to show that a rural preceptorship is about learning to balance the competing scripts of health care policy and the tacit, rural code of kinship-like bonds with clients and colleagues. Landscape photographs provided a concrete means of expressing these multiple roles and the ways in which rural nurses negotiate them. Moreover, the students showed that they had adopted their preceptors’ holistic view of health, in which community and the landscape it inhabits are seen as primary determinants of client needs.

For nursing instructors and prospective rural preceptees, this is valuable contextual information (Bushy & Leipert, 2005; Edwards et al., 2004; World Health Organization, 2010; Zawaduk, 2011). For rural health care agencies wishing to recruit new nurses, these images and the insights they elicited constitute a powerful means of delivering a message: rural nursing is a specialized discipline with unique challenges and rewards. Our participants also made it clear they wished policymakers to receive the same message.

The findings illustrate that rural nurses have a dichotomous relationship with landscape. The highway provided a scenic respite for the nurses and students who took part in our study, but they also saw travel as an impediment to care, and a major source of accidents. Likewise, the manifestations of local primary industries (chiefly farming and natural resource extraction) were perceived to be the economic engine of the community, but they also represented health hazards that constituted a crucial aspect of a rural nurse’s contextual knowledge and work.

Owing to their high community visibility in sparsely populated areas, rural nurses must constantly shift between professional and community roles, both on and off the job (Long & Weinert, 2010; Mills et al., 2007). This is a defining feature of rural nursing, and it underpins rural nurses’ dichotomous attitudes toward much of their surroundings. Glimpsing a round hay bale, a rural nurse may feel the comfort of knowing that her family will be able to keep the livestock fed, coupled with the dread borne of having treated farm workers with broken necks from falling bales, and the very real prospect that the next injury might be to a friend or loved one.

“When people are walking in from a car accident, we know them,” said Sharon (preceptor). “When there’s a teenager badly injured in a rollover, that’s probably our kid’s best friend.”

Zawaduk (2011, p. 34) points out that urban educated students “can expect cultural dissonance, or a sense of discomfort or confusion, as [they] come to take on the role of a rural nurse”. For our participants, landscape photographs proved a means of objectifying and rationalizing the opposing values in play. It was easier to explain in terms of hay bales and pump jacks how one could simultaneously experience the *Gemeinschaft* pull of community bonds, while working in the *Gesellschaft* policy-driven world of health care.

Certain landscapes also gave occasion for a message to policymakers. Sharon (preceptor) took several photographs of a new acute care wing at her hospital, but was unimpressed with the fanfare accompanying its opening, attended by several legislators. “We were really kicking ourselves because we had all written letters of concern [regarding staff cutbacks]... and we should have delivered them right there.” The sentiment is congruent with Meg’s (preceptor) sardonic take on the provincial tourism slogan, “Land of Living Skies”: an instinctive, *Gemeinschaft* resistance to the patronizing attitude of centralized policymakers who adopt a one-size-fits-all approach, marginalizing the voices of local stakeholders (Jackman et al., 2010).

Bollman and Reimer (2009, p. 140) provide a useful reminder to policymakers across the country: “Once you’ve seen one rural community, you’ve seen one rural community.” This point was self-evident in our participants’ photographs of their communities. The history and character of each town were absolutely unique, even given common occupational elements of landscape. Different ethnicities, patterns of settlement over generations, and socioeconomic factors all contribute to a community’s individuality, to say nothing of rural residents’ tireless determination to set themselves apart from the town down the road (curious motorists on the Canadian prairies perennially find themselves stopping at the home of the “World’s Largest” something). In the face of such variability, the sameness of modern rural hospitals, many designed by the same urban architect commissioned by the provincial government, seems an impersonal *Gesellschaft* intrusion on a *Gemeinschaft* landscape of personal bonds.

The less sympathetic view of rural *Gemeinschaft* as misleading or marginalizing to outsiders (Castleden et al., 2010; Watkins & Jacoby, 2007) might also resonate with rural nurse preceptors and their students. Rural residents may not always live up to the open, accepting nature they see symbolically projected in their surroundings, something to which Sharon (preceptor) alluded at the end of a follow-up session: “You don’t come out of the closet in this town.” Occupational and ethnic elements of landscape, such as churches and monuments, can encode traditional, social mores that tend to exclude newcomers with different values or backgrounds. For nursing students undertaking rural preceptorships, this is also an important consideration.

6.0 Conclusion

Landscape pictures were singularly useful in drawing out the competing viewpoints that inform a rural nursing preceptorship: nurse versus neighbor, policy versus kinship, *Gesellschaft* versus *Gemeinschaft*. The images and comments elicited, in the form of our online presentation and book, will ideally serve to

increase the profile of marginalized stakeholders, such as our participants, in matters of rural health care education and policy, and in keeping with the ultimate rationale of photovoice (Wang & Burris, 1997). An enhanced understanding of this vital yet marginalized specialization may in turn help to arrest the decline of rural health care provision in Canada and elsewhere.

7.0 Acknowledgments

The authors gratefully acknowledge the contributions of all primary participants, as well as their co-workers, friends, and family members who agreed to take part. The authors would like to acknowledge the work of research assistants Jim Cockell (MA) and Judy McTavish (BScN). The authors would also like to acknowledge the Social Science and Humanities Research Council (SSHRC) of Canada for funding this research project.

8.0 References

- Bollman, R., & Reimer, W. (2009). Demographics, employment, income, and networks: differential characteristics of rural populations. *Journal Of Agromedicine*, 14(2), 132-141.
- Bushy, A., & Leipert, B. (2005). Factors that influence students in choosing rural nursing practice: A pilot study. *Rural and Remote Health*, 5, 387.
- Canadian Institute for Health Information. (2002). *Supply and distribution of Registered Nurses in rural and small town Canada*. Ottawa, Ontario: Author.
- Canadian Institute for Health Information. (2006). *Workforce trends of Registered Nurses in Canada, 2005*. Ottawa, Ontario: Author.
- Castleden, H., Crooks, V., Schuurman, N., & Hanlon, N. (2010). "It's not necessarily the distance on the map...": using place as an analytic tool to elucidate geographic issues central to rural palliative care. *Health & Place*, 16(2), 284-290.
- Catalani, C., & Minkler, M. (2010). Photovoice: A review of the literature in health and public health. *Health Education & Behavior*, 37(3), 424-451.
- Durrell, L. (1957). *Justine*. London: Faber & Faber, 1957. Toronto: Penguin Books Canada, Ltd., 1991.
- Edwards, H., Smith, S., Courtney, M., Finlayson, K., & Chapman, H. (2004). The impact of clinical placement location on nursing students' competence and preparedness for practice. *Nurse Education Today*, 24, 248-255.
- Harrison, B. (2002). Seeing health and illness worlds – using visual methodologies in sociology of health and illness: A methodological review. *Sociology of Health & Illness*, 24(6), 856-872.
- Hergenrather, K., Rhodes, S., Cowan, C., Bardhoshi, G., & Pula, S. (2009). Photovoice as community-based participatory research: A qualitative review. *American Journal of Health Behavior*, 33(6), 686-698.
- Hudson, M. J., Aoyama, M., Diab, M., & Aoyama, H. (2011). The South Tyrol as occupationscape: Occupation, landscape, and ethnicity in a European border zone. *Journal of Occupational Science*, 18(1), 21-35.

- Jackman, D., Myrick, F., & Yonge, O. (2010). Rural nursing in Canada: A voice unheard. *Online Journal of Rural Nursing and Health Care*, 10(1), 60-69.
- Leipert, B., & Anderson, E. (2012). Rural nursing education: a photo voice perspective. *Rural & Remote Health*, 12(2), 1-11.
- Long, K., & Weinert, C. (2010). Rural nursing: Developing the theory base. In C. A. Winters & J. H. Lee (Eds.), *Rural Nursing: Concepts, Theory and Practice* (pp. 3-17). New York: Springer.
- Mills, J., Francis, K., & Bonner, A. (2007). Live my work: rural nurses and their multiple perspectives of self. *Journal of Advanced Nursing*, 59(6), 583-590.
- Neill, J., & Taylor, K. (2002). Undergraduate nursing students' clinical experiences in rural and remote areas: Recruitment implications. *Australian Journal of Rural Health*, 10, 239-243.
- Tönnies, F. (1887/2002). *Community and society* [Gemeinschaft und Gesellschaft] (C. Loomis, Trans. & Ed.). Dover, England: Dover Publications.
- Van Hofwegen, L., Kirkham, S., & Harwood, C. (2005). The strength of rural nursing: Implications for undergraduate nursing education. *International Journal of Nursing Education Scholarship*, 2(1), 1-13.
- Wang, C., & Burris, A. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education and Behavior*, 24(3), 369-387.
- Watkins, F., & Jacoby, A. (2007). Is the rural idyll bad for your health? Stigma and exclusion in the English countryside. *Health & Place*, 13(4), 851–864.
- Weinert, C., & Burman, M. (1999). "The sampler quilt: A metaphor of rural communities." In A. S. Hinshaw, S. L. Feetham, & J. Shaver (Eds.), *Handbook of clinical nursing research* (pp. 75-86). Thousand Oaks, CA: Sage Publications.
- Wendling, L., DeDoner, J., Schmidt, L., Calhoun, J., & Jarvis, K. (2005). Learning through shared meaning: Nursing students' perceptions of rural Kansas. *The Kansas Nurse*, 80(5), 1-3.
- World Health Organization. (2010). *Increasing access to health workers in remote and rural areas through improved retention*. Geneva: World Health Organization.
- Zawaduk, C. (2011). *It takes a village: Rural nursing preceptorships as cultural mediation*. Unpublished doctoral dissertation, Simon Fraser University, Burnaby, BC, Canada. (Simon Fraser University Library ETD No. 6463). Retrieved June 1, 2011 from Simon Fraser University Library online.